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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility had a census of 8 residents. The sample included 8 residents and 1 closed. Based upon observation, record review and interview the facility failed to ensure full side rails were the least restrictive device for 1 of 3 (#20) residents sampled for restraint review. Findings included: - Resident #20's admission Minimum Data Set (MDS) 3.0 dated 12/1/14 identified the resident scored 7 (severely impaired cognition) on the Brief Interview for Mental Status, had no behaviors, required limited staff assistance with bed mobility, walking in the room/corridor, extensive staff assistance with transfers, locomotion on the unit, dressing, toilet use and personal hygiene. The MDS identified the resident was not steady, was only able to stabilize with human assistance when moving from seated to standing position, walking, turning around and facing the opposite direction while walking and surface to surface transfers. The MDS recorded the resident had no functional limitation in range	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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of motion, utilized a walker and was always continent of urine. The MDS identified the resident had no falls/fractures prior to admission and had (1) non-injury fall since admission and did not utilize restraints.

The resident's Cognition Loss Care Area Assessment (CAA) dated 12/1/14 included the resident had no documented memory loss, was alert to self but not to time or place.

The resident's Activity of Daily Living CAA dated 12/1/14 included the resident received physical therapy.

The resident's Fall CAA dated 12/1/14 included the resident was at risk for falls, had slid out of bed once since admission. The resident was a safety concern, staff assisted the resident with mobility and utilized a bed and chair alarm to alert staff if the resident attempted to transfer without staff assistance.

The resident's care plan reviewed on 12/2/24 included the resident had impaired functional mobility, staff ensured the resident used assistive devices, received functional mobility training and restorative nursing care. The resident easily lost his/her balance, was confused at night, attempted to get out of bed by himself/herself and utilized a bed/chair alarm. The resident transferred with assistance of 1 staff, was unsteady while walking and required staff assistance and required staff assistance to stand from a sitting position. The resident had sustained a non-injury fall since admission.

The resident's care plan did not include the resident utilized side rails.

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The resident's injury risk assessment and intervention dated 11/24/14 included the resident was at risk for rolling out/sliding out of bed due to impaired lower extremity mobility and the resident utilized full bed rails in the raised position to prevent rolling/sliding.

A nurse's note (NN) dated 12/1/14 and timed 12:54 A.M. included the resident had a bed alarm in place for safety, the resident repositioned himself/herself in bed, and the resident's bed rail were raised per family request.
A NN dated 12/3/14 and timed 12:45 A.M. documented the resident's bed alarm activated, and staff found the resident sitting cross legged on the floor next to his/her bed facing the head of the bed with his/her right arm on the bed. The resident's upper (2) side rails were raised, and staff raised all 4 of the side rails to prevent the resident from slipping out of the bed.

The resident's clinical record lacked evidence to support the facility thoroughly assessed the resident to ensure the 4 raised side rails were the least restrictive device for the resident.

On 12/2/14 at 8:35 A.M. the resident laid in bed and the upper (2) side rails were in the raised position.

On 12/4/14 at 7:45 A.M. the resident was in bed and observation revealed all 4 side rails were in the raised position.

On 12/3/14 at 8:10 A.M. the resident's bed alarm activated and direct care staff O and licensed nurse H were in the hallway. At that time licensed nurse H stated the activated alarm was the

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resident's bed alarm. The surveyor and licensed nurse H entered the resident's room and a laboratory staff assisting the resident's roommate stated the resident got out of bed and made it to bathroom without staff assistance and that direct care staff O was in the bathroom with the resident. At 8:20 A.M. direct care staff O assisted the resident from the bathroom via a gait belt. Observation revealed the resident had a wobbly and unsteady gait.

On 12/3/14 at 12:35 P.M. the resident laid in bed and all 4 side rails were in a raised position. During interview with a family member of the resident's at that time, the family member stated all 4 side rails were raised to prevent the resident from getting out of bed.

On 12/4/14 at 9:06 A.M. licensed nurse L stated all resident's upper side rails were raised. He/she stated if facility staff raised the lower 2 rails as well as the upper side rails then the rails were considered a restraint. Licensed nurse L stated the resident's family requested the facility raised the resident's lower 2 side rails therefore the 4 raised side rails were not considered a restraint.

On 12/4/14 at 12:55 P.M. direct care staff L stated the resident was at risk for falls. Staff performed hourly rounds, offered toileting to the resident, the resident had a bed alarm and and after the resident's family member left for the day, staff raised all 4 of the resident's side rails to prevent the resident from sliding/rolling out of the bed.

On 12/4/14 at 1:13 P.M. administrative nursing staff D stated the resident was at risk for falls. The resident wore a fall risk bracelet, had a fall

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F 221	Continued From page 4 risk sign on his/her door, performed hourly rounds, utilized a bed/chair alarm and utilized side rails times 4 to prevent the resident from sliding out of bed. Licensed staff D stated the 4 side rails in the raised position were not considered a restraint because the raised side rails prevented the resident from rolling/sliding out of bed. Licensed nurse D stated all resident's upper side rails were in the raised position when the resident was in bed and this resident's family member requested all 4 side rails were to be in the raised position. The facility's Restraint Policy dated May 2013 included side rails when used as an assistive device for the resident, at the resident's request, to prevent the resident from rolling out of bed... did not meet the definition of a restraint. The facility failed to identify and thoroughly assess and siderails as a potential restraint. The facility further failed to implement alternative methods prior to raising the resident's side rails per family request.	F 221		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		

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assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 8 residents. The sample size included 8 residents and 1 resident closed record. Based on record review and interview the facility failed to accurately complete the Minimum Data Set (MDS) for 1 resident (# 53).

Findings included:

- The 5 day Minimum Data Set (MDS) dated 7/22/14 revealed resident # 53 had a stage 3 pressure ulcer upon admission that measured 2.0 (centimeters) cm (x) by 1.1 cm x 0.1 cm. The resident required extensive assistance of two staff members for bed mobility, transfers and toilet use.

According to the initial wound assessment on 7/15/14 upon entry of facility revealed the resident

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had a stage 2 pressure ulcer on the coccyx which measured 2.1 cm x 1.5 cm x 0.5 cm.

The Admission Minimum Data Set (MDS) dated 7/28/14 revealed the resident had a stage 3 pressure ulcer upon admission that measured 1.9 cm x 1.0 cm x 0.1 cm. The resident required extensive assistance of two staff members for bed mobility, transfers and toilet use.

The Pressure ulcer Care Area Assessment dated 7/28/14 revealed a stage 3 pressure ulcer on coccyx present upon admission.

The discharge MDS dated 8/15/14 revealed the resident had a stage 3 pressure ulcer that was present on admission which measured 2.5 cm x 1.5 cm x 0.2 cm.

The care plan revised on 8/12/14 revealed the resident had a stage 3 pressure ulcer on the coccyx, and staff assisted the resident every 2 hours with repositioning.

Wound assessment dated 8/14/14 revealed the coccyx wound was a stage 3 pressure ulcer which measured 2.9 cm x 1.4 cm x 0.15 cm.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and voiced the 5 day, admission and discharge assessment were coding incorrectly. Resident #53 came into the facility with a stage 2 pressure ulcer and while in facility became a stage 3 pressure ulcer.

The Resident Assessment Instrument (RAI) policy and procedure revised on July 2013 revealed the facility would complete the RAI

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F 278	Continued From page 7 process in a timely manner that maintained compliance with state and federal guidelines. The facility failed to accurately complete the 5 day, admission and discharge MDS accurately for this resident whose pressure ulcer was a stage 2 when admitted and became a stage 3 pressure ulcer while in the facility.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility identified a census of 8 residents. The sample included 8 residents and one closed record. Based on observation, record review and interview the facility failed to include medications that have a black box warning and failed to address targeted behaviors on the interim care plan for 2 residents (#66, #67, Findings included: - The 5 day Minimum Data Set (MDS) dated 11/26/14 revealed resident # 66 received anticoagulants (a medication given to thin blood), antibiotics and diuretics (medication to promote the formation and excretion of urine). The care plan updated on 12/2/14 lacked information that the resident had insomnia (trouble sleeping), or that he/she received medications that had a black box warning (a warning issued by the FDA (US food and drug administration) is a warning of serious or	F 281		

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life-threatening risks located on the label of a prescription drug (BBW). The care plan lacked identification that he/she used side rails.

Review of the electronic medication record (EMAR) revealed the resident had the following orders that are BBW and were not addressed on the care plan:
Lunesta (a hypnotic (a psychotropic medication) given for insomnia) 1 milligram (mg) by mouth (PO) as needed (PRN) daily for sleep and had an order date of 11/20/14. The resident received this medication 11/20/14, 11/21/14 and 11/29/14.
Lotensin (an anti-hypertensive (elevated blood pressure) medication) 10 mg PO once daily (A.M.) ordered on 11/21/14. Furosemide (a diuretic (medication to promote the formation and excretion of urine) medication) 20 mg PO ordered on 11/21/14 which lacked a diagnosis. Warfarin (a medication used to thin the blood) 2 mg PO Every P.M. ordered on 12/1/14.

Observation on 12/2/14 at 4:25 P.M. resident slept in bed with the top two half side rails in the up position.

Interview on 12/4/14 at 8:04 A.M. with direct care staff Q stated the resident voiced his/her needs appropriately, and did not have access for updating the care plans.

On 12/4/14 at 9:06 A.M. licensed nursing staff M revealed nursing staff reviewed the care plans daily and revised as needed, he/she voiced BBW and side rails were not listed on the care plan. The MDS coordinator reviewed the care plans weekly.

On 12/4/14 at 11:02 A.M. administrative licensed

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nursing staff D revealed nursing staff were responsible for care plan updates and the pharmacy does the high risk medications, but does not put them on the care plan. He/she voiced all the beds on the floor had side rails and were not addressed on the care plan.

The policy and procedure revised on July 2013 for Transitional care unit structure standards provided by the facility revealed nursing staff reviewed the care plan daily and PRN with changes in the patients condition, the policy lacked identification of BBW or side rails.

The facility failed to identify and include BBW medications and side rails in this residents care plan who received BBW medications and used side rails.

- The electronic medical record revealed resident # 67 was admitted on 11/26/14.

The care plan updated on 12/2/14 revealed the resident received psychotropic medication and staff monitored for this behavior, but the care plan lacked targeted behaviors. The care plan lacked what black box warning (a warning issued by the FDA (US food and drug administration) is a warning of serious or life-threatening risks located on the label of a prescription drug (BBW).

Review of the electronic medication record (EMAR) revealed the resident had the following orders that are BBW and were not addressed on the care plan:
Metoprolol (an anti-hypertensive (elevated blood pressure) medication) 25 milligrams (mg) by mouth (PO) two times daily with an order date of 11/26/14, Furosemide (a diuretic (medication to

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promote the formation and excretion of urine) medication) 20 mg PO ordered on 11/27/14 which lacked a diagnosis.

Observation on 12/3/14 at 9:10 A.M. resident visited with tablemate's in the dining room.

Interview on 12/4/14 at 8:04 A.M. with direct care staff Q stated the resident voiced his/her needs appropriately, and did not have access for updating the care plans.

On 12/4/14 at 9:06 A.M. licensed nursing staff M revealed nursing staff reviewed the care plans daily and revised as needed, he/she voiced BBW and side rails were not listed on the care plan. The MDS coordinator reviewed the care plans weekly.

On 12/4/14 at 11:02 A.M. administrative licensed nursing staff D revealed nursing staff were responsible for care plan updates and the pharmacy does the high risk medications, but does not put them on the care plan. He/she voiced all the beds on the floor had side rails and were not addressed on the care plan.

The policy and procedure revised on July 2013 for Transitional care unit structure standards provided by the facility revealed nursing staff reviewed the care plan daily and PRN with changes in the patients condition, the policy lacked identification of BBW or side rails.

The facility failed to identify and include BBW medications and side rails in this residents care plan who received BBW medications and used side rails.

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F 287 SS=E	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 287		

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reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 8 residents. The sample included 8 residents and 1 closed record. Based on record review and interview the facility failed to complete the entry tracking record within the resident assessment instrument (RAI) for 9 residents (# 20, #69, #67, # 11, #38, # 68, #53, # 66 and #70).

Findings included:

- Review of the electronic medical record revealed resident # 53 entered the facility on 7/15/14. The facility failed to complete an Entry tracking record within the RAI.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and had never done the entry tracking on resident's before.

The Resident Assessment Instrument (RAI) policy and procedure revised on July 2013 revealed the facility would complete the RAI process in a timely manner that maintained compliance with state and federal guidelines.

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The facility failed to conduct an Entry tracking record for this resident, according to the RAI process.

- Review of the electronic medical record revealed resident # 11 entered the facility on 11/23/14. The facility failed to complete an Entry tracking record within the RAI.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and had never done the entry tracking on resident's before.

The Resident Assessment Instrument (RAI) policy and procedure revised on July 2013 revealed the facility would complete the RAI process in a timely manner that maintained compliance with state and federal guidelines.

The facility failed to conduct an Entry tracking record for this resident, according to the RAI process.

- Review of the electronic medical record revealed resident # 69 entered the facility on 11/24/14. The facility failed to complete an Entry tracking record within the RAI.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and had never done the entry tracking on resident's before.

The Resident Assessment Instrument (RAI) policy and procedure revised on July 2013

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revealed the facility would complete the RAI process in a timely manner that maintained compliance with state and federal guidelines.

The facility failed to conduct an Entry tracking record for this resident, according to the RAI process.

- Review of the electronic medical record revealed resident # 70 entered the facility on 11/25/14. The facility failed to complete an Entry tracking record within the RAI.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and had never done the entry tracking on resident's before.

The Resident Assessment Instrument (RAI) policy and procedure revised on July 2013 revealed the facility would complete the RAI process in a timely manner that maintained compliance with state and federal guidelines.

The facility failed to conduct an Entry tracking record for this resident, according to the RAI process.

- Review of the electronic medical record revealed resident # 66 entered the facility on 11/26/14. The facility failed to complete an Entry tracking record within the RAI.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and had never done the entry tracking on resident's before.

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F 287	Continued From page 15 The Resident Assessment Instrument (RAI) policy and procedure revised on July 2013 revealed the facility would complete the RAI process in a timely manner that maintained compliance with state and federal guidelines. The facility failed to conduct an Entry tracking record for this resident, according to the RAI process. - Review of the electronicmedical record revealed resident # 67 entered the facility on 11/26/14. The facility failed to complete an Entry tracking record within the RAI. Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and had never done the entry tracking on resident's before. The Resident Assessment Instrument (RAI) policy and procedure revised on July 2013 revealed the facility would complete the RAI process in a timely manner that maintained compliance with state and federal guidelines. The facility failed to conduct an Entry tracking record for this resident, according to the RAI process. - Resident #20's admission Minimum Data Set (MDS) 3.0 dated 12/1/14 identified the resident was admitted to the facility on 11/18/14. Review of the residents clinical record lacked evidence the facility did an entry tracking record.	F 287		

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F 287	Continued From page 16 On 12/2/14 at 8:35 A.M. the resident laid in bed. During interview with administrative nursing staff on 12/3/14 at approximately 11:00 A.M. he/she stated the facility did not complete entry tracking records. According to the Minimum Data Set manual entry tracking records are part of the Resident Assessment Instrument and must be completed no later than entry date plus 7 calendar days. The facility failed to complete the required entry tracking record. - Resident #68's clinical record identified the resident was admitted to the facility on 11/26/14 with hospice services. Review of the residents clinical record lacked evidence the facility did an entry tracking record. On 12/2/14 at 8:00 A.M. the resident laid in bed. During interview with administrative nursing staff on 12/3/14 at approximately 11:00 A.M. he/she stated the facility did not complete entry tracking records. According to the Minimum Data Set manual entry tracking records are part of the Resident Assessment Instrument and must be completed no later than entry date plus 7 calendar days. The facility failed to complete the required entry tracking record. - Resident #38's (a closed record) clinical record	F 287		

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F 287	Continued From page 17 identified the resident was admitted to the facility on 8/15/14 and discharged from the facility on 8/29/14. Review of the residents clinical record lacked evidence the facility did an entry tracking record. During interview with administrative nursing staff on 12/3/14 at approximately 11:00 A.M. he/she stated the facility did not complete entry tracking records. According to the Minimum Data Set manual entry tracking records are part of the Resident Assessment Instrument and must be completed no later than entry date plus 7 calendar days. The facility failed to complete the required entry tracking record.	F 287		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 8 residents. The sample included 8 residents and 1 closed record. Based on record review and interview resident	F 314		

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#53's (closed record) pressure ulcer increased in size and stage.

Findings included:

- The 5 day Minimum Data Set (MDS) dated 7/22/14 revealed resident # 53 had a stage 3 pressure ulcer upon admission that measured 2.0 (centimeters) cm (x) by 1.1 cm x 0.1 cm. The resident required extensive assistance of two staff members for bed mobility, transfers and toilet use.

The Pressure ulcer Care Area Assessment dated 7/28/14 revealed a stage 3 pressure ulcer on coccyx present upon admission.

The discharge MDS dated 8/15/14 revealed the resident had a stage 3 pressure ulcer that was present on admission which measured 2.5 cm x 1.5 cm x 0.2 cm.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she completed the MDS process and voiced the 5 day, admission and discharge assessment were coding incorrectly. Resident #53 came into the facility with a stage 2 pressure ulcer and while in facility became a stage 3 pressure ulcer.

The care plan revised on 8/12/14 revealed the resident had a stage 3 pressure ulcer on the coccyx, and staff were to assist the resident every 2 hours with repositioning.

Initial wound assessment on 7/15/14 upon entry of facility revealed the resident had a stage 2 pressure ulcer on the coccyx which measured 2.1 cm x 1.5 cm x 0.5 cm.

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Wound assessment dated 8/1/14 revealed the coccyx wound was a stage 3 pressure ulcer which measured 2.5 cm x 1.5 cm x 0.2 cm.

Wound assessment dated 8/14/14 revealed the coccyx wound was a stage 3 pressure ulcer which measured 2.9 cm x 1.4 cm x 0.15 cm.

The dietitian's assessments revealed on 7/25/14 a recommendation of ensure 2 times daily and again on 8/4/14 weight has declined and intake declined continue ensure two times daily.

Review of the Physician progress notes dated 7/15/14 through 8/15/14 revealed the resident had a stage 2 pressure ulcer during his/her stay.

The record lacked documentation that the facility had notified the physician of the residents pressure ulcer worsening from a stage 2 to a stage 3 pressure ulcer. The record did document a change in treatment requested when the wound got worse.

Interview on 12/3/14 at 9:59 A.M. administrative nursing staff D revealed he/she was the wound nurse and charted on wounds at least weekly, which was not done on resident # 53. He/she stated the physician would be notified if a wound increased in size. Administrative nursing staff D revealed he/she could not find documentation the physician was notified of the increase in size of the pressure wound, neither did she document a request for a wound consult which they normally do.

The policy and procedure for wound care management dated 4/28/14did not addresswhat

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F 314	Continued From page 20 to do whane a pressure wound that got worse. The clinical record lacked evidence to show the worsening of the pressure ulcer was unavoidable. The record also lacked evidence the physician was notified that the pressure ulcer got larger and increased in stage.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 8 residents. The sample included 8 residents and 1 closed record. Based upon observation, record review and interview the facility failed to provide effective interventions for (1) resident (#20) to minimize falls. Findings included: - Resident #20's admission Minimum Data Set (MDS) 3.0 dated 12/1/14 identified the resident scored 7 (severely impaired cognition) on the Brief Interview for Mental Status, had no behaviors, required limited staff assistance with bed mobility, walking in the room/corridor, extensive staff assistance assistance with transfers, locomotion on the unit, dressing, toilet	F 323		

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use and personal hygiene. The MDS identified the resident was not steady, was only able to stabilize with human assistance when moving from seated to standing position, walking, turning around and facing the opposite direction while walking and surface to surface transfers. The MDS recorded the resident had no functional limitation in range of motion, utilized a walker and was always continent of urine. The MDS identified the resident had no falls/fractures prior to admission and had (1) non-injury fall since admission.

The resident's Cognition Loss Care Area Assessment (CAA) dated 12/1/14 included the resident had no documented memory loss, was alert to self but not to time or place.

The resident's Activity of Daily Living CAA dated 12/1/14 included the resident received physical therapy.

The resident's Fall CAA dated 12/1/14 included the resident was at risk for falls, had slid out of bed one time since admission. The resident was a safety concern, staff assisted the resident with mobility and utilized a bed and chair alarm to alert staff if the resident attempted to transfer without staff assistance.

The resident's Injury Risk Assessment dated 11/18/14 and 12/2/14 included the resident was at risk for fall, staff taught the resident and family how to use call system, how to operate the bed and activity limitations. Staff ensured the resident's call light, over bed light cord, and frequently used personal items were within the resident's reach, locked the brakes on the resident's bed and wheelchair when not in transit

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and ensured the resident's bed was at the lowest functional height when direct care was not provided. Staff encouraged the resident to call for help as needed and the resident wore non-skid footwear when out of bed. Staff placed a fall prevention sign on the resident's room door, the resident wore a fall risk identification band, staff performed hourly check when the resident was awake, staff stayed with resident when the resident used the commode, the resident utilized a bed alarm/chair alarm. Staff assessed the resident's need for restorative nursing, physical/occupational therapy and a pharmacist consultation.

The resident's care plan reviewed on 12/2/24 included the resident had impaired functional mobility, staff ensured the resident used assistive devices, received functional mobility training and restorative nursing care. The resident easily lost his/her balance, was confused at night, attempted to get out of bed by himself/herself and utilized a bed/chair alarm. The resident transferred with assistance of 1 staff, was unsteady while walking and required staff assistance to stand from a sitting position. The resident had sustained a non-injury fall since admission.

The resident's Kardex updated 12/2/14 included the resident was on strict fall precautions, had a fall prevention sign on his/her room door, wore a fall risk identification band , staff checked on the resident on an hourly basis, offered toileting assistance hourly while awake, staff stayed with the resident when he/she used the bathroom and replaced the resident's bed/chair alarms.

A nurses' note (NN) dated 11/18/14 and timed 8:45 P.M. included the resident arrived to the unit

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via a wheelchair and acute care staff reported the resident had some confusion at night and was only alert to self. Staff placed a bed alarm and a fall band identification bracelet to alert staff of the resident's safety needs.

A NN dated 11/23/14 and timed 11:55 P.M. included at 11:30 P.M. the resident called for help. The resident laid on his/her abdomen on the floor. Two staff returned the resident the bed via a gait bed. Staff replaced the resident's bed alarm and the bed alarm strip.

An injury risk assessment ad intervention dated 12/2/14 timed 9:37 A.M. included the resident's last fall risk consultation was performed on 11/24/14. The resident's was on strict fall precautions which included a fall prevention sign on the door, fall risk identification band, hourly checks by staff, staff offered hourly toileting when the resident was awake and staff remained with the resident when/she used the bathroom.

A NN dated 12/3/14 and timed 12:45 A.M. documented the resident's bed alarm activated, and staff found the resident sitting cross legged on the floor next to his/her bed facing the head of the bed with his/her right arm on the bed. A large area of the floor around the door side of the bed and past the foot of the bed was wet with water.

An injury risk assessment and intervention dated 12/3/14 timed 12:59 A.M. included the resident had 2 or more falls within the last 6 months. The resident last fall was on 12/3/14, the resident's was on strict fall precautions which included a fall prevention sign on the door, fall risk identification band, hourly checks by staff, staff offered hourly toileting when the resident was awake and staff

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remained with the resident when/she used the bathroom.

On 12/2/14 at 8:35 A.M. the resident laid in bed.

On 12/3/14 at 8:10 A.M. the resident's bed alarm activated and direct care staff O and licensed nurse H were in the hallway. The surveyor and licensed nurse H entered the resident's room and a laboratory staff assisting the resident's roommate stated the resident got out of bed and made it to bathroom without staff assistance and that direct care staff O was in the bathroom with the resident. At 8:20 A.M. direct care staff O assisted the resident from the bathroom via a gait belt. Observation revealed the resident had a wobbly and unsteady gait.

On 12/4/14 at 12:51 P.M. licensed nurse I stated the resident was at risk for falls. Staff performed hourly rounds, ensured the resident's call light was within reach, offered the resident the urinal, ensured the resident's trash can was in reach and ensured the resident's bed/chair alarm was plugged in all the time because the resident did not activate the call light.

On 12/4/14 at 12:55 P.M. direct care staff L stated the resident was at risk for falls. Staff performed hourly rounds, offered toileting to the resident and the resident had a bed alarm.

On 12/4/14 at 1:13 P.M. licensed staff D stated the resident was at risk for falls. The resident wore a fall risk bracelet, had a fall risk sign on his/her door, performed hourly rounds, utilized a bed/chair alarm and utilized side rails times 4 to

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F 323	Continued From page 25 prevent the resident from sliding out of bed. The facility's Fall Prevention Policy approved in April 2013 included implementation of interventions to minimize the potential risk for falls. The facility failed to implement effective and timely interventions for this resident with a history of falls.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 8 residents. The sample size included 8 residents and 1 closed record. Based on observation, record review and interview the facility failed to identify target behaviors for residents who received psychotropic medication for 4 residents (# 66, # 67, # 68, and # 70) of 5 residents sampled.

Findings included:

- The 5 day Minimum Data Set (MDS) dated 11/26/14 revealed resident # 66 received anticoagulants (a medication given to thin blood), antibiotics and diuretics (medication to promote the formation and excretion of urine).

The care plan updated on 12/2/14 lacked information that the resident had insomnia (trouble sleeping).

Review of the electronic medication record revealed the resident had an order for Lunesta (a hypnotic (a psychotropic medication) given for insomnia) 1 milligram (mg) by mouth (PO) as needed (PRN) daily for sleep and had an order date of 11/20/14. The resident received this medication 11/20/14, 11/21/14 and 11/29/14.

Review of the behavior monitoring flow sheet for Lunesta revealed the resident had received this medication on 11/28/14. The behavior monitoring flow sheet for Lunesta lacked targeted behaviors and was not put into effect until 11/28/14, 8 days after the medication was ordered for the resident.

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The December behavior monitoring flowsheet for Lunesta lacked targeted behaviors.

Observation on 12/2/14 at 4:25 P.M. resident slept while in bed.

On 12/3/14 at 8:39 A.M. resident stated he/she has never slept well at night and preferred to take naps during the day.

Interview on 12/4/14 at 8:04 A.M. with direct care staff Q stated the resident voiced his/her needs appropriately, and did take naps during the day.

On 12/4/14 at 9:06 A.M. licensed nursing staff M revealed behavior monitoring sheets were put into effect as soon as a resident was admitted or when the medication was ordered. He/she stated all behavior monitoring flow sheets had target behaviors and if a PRN medication was given the electronic medical record (EMAR) and behavior monitoring flow sheets would reflect this.

On 12/4/14 at 11:02 A.M. administrative licensed nursing staff D revealed the nurse who admitted the resident put into effect behavior monitoring flow sheets with target behaviors listed. He/she expected the behavior monitoring flow sheet to reflect the EMAR.

On 12/4/14 at approximately 1:20 P.M. pharmacy consultant GG stated he/she expected nursing staff to identify target behaviors and the behavior monitoring flow sheets to reflect the EMAR. He/she stated since the residents at this facility are here such a short time pharmacy staff try to review the behavior monitoring sheets weekly.

The policy and procedure revised on April 2011

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for behavior monitoring flow sheet provided by the facility revealed nursing staff would initiate a behavior monitoring flow sheet which included behaviors to be monitored upon admission or upon initiation of a medication. Nursing staff would document on this flow sheet the number of times this behavior occurred.

The facility failed to identify specific behaviors that needed monitoring for this resident who received a psychotropic medication.

- The electronic medical record revealed resident # 67 was admitted on 11/26/14.

The care plan updated on 12/2/14 revealed the resident experienced anxiety and staff monitored for this behavior.

Review of the electronic medication record revealed the resident had an order for Xanax (a medication used for anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) 0.25 milligrams (mg) by mouth (PO) as needed (PRN) for anxiety three times a day with an order date of 11/26/14.

Review of the behavior monitoring flow sheet for Xanax revealed the November and December flow sheets lacked targeted behaviors for Xanax.

Observation on 12/3/14 at 9:10 A.M. resident visited with tablemate's in the dining room.

Interview on 12/4/14 at 8:04 A.M. with direct care staff Q stated the resident voiced his/her needs appropriately, and had no behaviors.

On 12/4/14 at 9:06 A.M. licensed nursing staff M

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revealed behavior monitoring sheets were put into effect as soon as a resident was admitted or when the medication was ordered. He/she stated all behavior monitoring flow sheets had target behaviors.

On 12/4/14 at 11:02 A.M. administrative licensed nursing staff D revealed the nurse who admitted the resident put into effect behavior monitoring flow sheets with target behaviors listed.

On 12/4/14 at approximately 1:20 P.M. pharmacy consultant GG stated he/she expected nursing staff to identify target behaviors and the behavior monitoring flow sheets to reflect the EMAR. He/she stated since the residents at this facility are here such a short time pharmacy staff try to review the behavior monitoring sheets weekly.

The policy and procedure revised on April 2011 for behavior monitoring flow sheet provided by the facility revealed nursing staff would initiate a behavior monitoring flow sheet which included behaviors to be monitored for upon admission or upon initiation of a medication. Nursing staff would document on this flow sheet the number of times this behavior occurred.

The facility failed to identify specific behaviors that needed monitoring for this resident who was ordered a psychotropic medication.

- The 5 day Minimum Data Set (MDS) dated 11/28/14 revealed resident # 70 received hypnotics (a medication used for sleep) and anxiety (a medication used for anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear)) medication.

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The care plan updated on 12/2/14 revealed the resident received psychotropic medications but lacked information on specific psychotropic medications the resident received and targeted behaviors.

Review of the electronic medication record revealed the resident had an order for Ativan (an anti-anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) medication)) 1 milligram (mg) by mouth (PO) as needed (PRN) every four hours for anxiety with an order date of 11/25/14. The resident received this medication daily 11/25/14-12/2/14. An order for Ambien (a hypnotic (a psychotropic medication) given for insomnia) 5 milligram (mg) by mouth (PO) as needed (PRN) daily for sleep and had an order date of 11/25/14. The resident received this medication 11/26/14, 11/29/14, 11/30/14 and 12/1/14.

Review of the November behavior monitoring flow sheet for Ativan revealed the resident had received this medication on 11/28/14 and 11/29/14. The behavior monitoring flow sheet for Ativan lacked targeted behaviors, and was not put into effect until 11/28/14, 4 days after the resident was ordered this medication.

Review of the November behavior monitoring flow sheet for Ambien revealed the resident had received this medication on 11/29/14. The behavior monitoring flow sheet for Ambien lacked targeted behaviors, and was not put into effect until 11/28/14, 4 days after the medication was ordered for the resident.

Review of the December behavior monitoring flow

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sheet for Ativan and Ambien revealed the resident received Ativan and Ambien on 12/1/14, both medications lacked documentation for targeted behaviors.

Observation on 12/1/14 at 11:33 A.M. resident voiced complaints of pain and he/she stated nursing staff gave him/her pain medications when he/she asked.

Interview on 12/4/14 at 8:04 A.M. with direct care staff Q stated the resident voiced his/her needs appropriately, and displayed agitation and was verbally abusive at times.

On 12/4/14 at 9:06 A.M. licensed nursing staff M revealed behavior monitoring sheets were put into effect as soon as a resident was admitted or when the medication was ordered. He/she stated all behavior monitoring flow sheets had target behaviors and if a PRN medication was given the electronic medical record (EMAR) and behavior monitoring flow sheets would reflect this.

On 12/4/14 at 11:02 A.M. administrative licensed nursing staff D revealed the nurse who admitted the resident put into effect behavior monitoring flow sheets with target behaviors listed. He/she expected the behavior monitoring flow sheet to reflect the EMAR.

On 12/4/14 at approximately 1:20 P.M. pharmacy consultant GG stated he/she expected nursing staff to identify target behaviors and the behavior monitoring flow sheets to reflect the EMAR. He/she stated since the residents at this facility are here such a short time pharmacy staff try to review the behavior monitoring sheets weekly.

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The policy and procedure revised on April 2011 for behavior monitoring flow sheet provided by the facility revealed nursing staff would initiate a behavior monitoring flow sheet which included behaviors to be monitored for upon admission or upon initiation of a medication. Nursing staff would document on this flowsheet the number of times this behavior occurred.

The facility failed to identify specific behaviors that needed monitoring for this resident who received a psychotropic medication.

- Review of resident #68 clinical record revealed the resident was admitted to the facility on 11/26/14 with hospice services.

The resident's care plan dated 12/1/14 included staff monitored the resident for pain, administered pain medications as physician ordered and the resident received hospice services.

The resident's care plan did not include Tylenol had a Black Box Warning (BBW-a warning to alert individuals and healthcare provider about any important safety concerns, such as serious side effects or life threatening risk.

Review of the resident's Medication Administration Record (MAR) from 11/26/14 to 12/3/14 included the resident had physician's orders to receive Tylenol 650 milligrams (mg) suppository every 4 hours, 650 mg (2) tablets every 4 hour as needed for pain/fever and do not exceed 4 grams in 24 hours.

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F 329	Continued From page 33 The resident's MAR did not identify Tylenol had a BBW. On 12/2/14 at 8:00 A.M. the resident laid in his/her bed. On 12/4/14 at 11:02 A.M. administrative nursing staff D stated BBW were included on the resident's MAR but not on the resident's care plan. On 12/4/14 at 1:00 P.M. pharmacist staff II stated the facility listed hazardous drug warnings but did not include BBW. Pharmacist staff II stated the facility did not lower Tylenol do not exceed limitation 4 grams to 3 grams per day. According to www.fda.gov <http://www.fda.gov> Tylenol had a black box warning of potential for severe liver injury and the potential for allergic reactions (e.g., swelling of the face, mouth, and throat, difficulty breathing, itching, or rash). According to Tylenol manufacturers for individuals receiving regular strength Tylenol (325 mg) the individual should not exceed 3 grams in 24 hours. The facility failed to ensure the resident did not exceed 3 grams of Tylenol in 24 hours and also failed to monitor for serious side effects.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		

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F 428	Continued From page 34 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 8 residents. The sample size included 8 residents and 1 closed record. Based on observation, record review and interview the consulting pharmacist failed to notify the facility that target behaviors for residents who received psychotropic medication were not listed on the behavioral monitoring flow sheets for 3 residents (# 66, # 67, # 70) of 5 residents sampled. Findings included: - The 5 day Minimum Data Set (MDS) dated 11/26/14 revealed resident # 66 received anticoagulants (a medication given to thin blood), antibiotics and diuretics (medication to promote the formation and excretion of urine). The care plan updated on 12/2/14 lacked information that the resident had insomnia (trouble sleeping). Review of the electronic medication record revealed the resident had an order for Lunesta (a hypnotic (a psychotropic medication) given for insomnia) 1 milligram (mg) by mouth (PO) as needed (PRN) daily for sleep and had an order date of 11/20/14. The resident received this medication 11/20/14, 11/21/14 and 11/29/14.	F 428		

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Review of the behavior monitoring flow sheet for Lunesta revealed the resident had received this medication on 11/28/14. The behavior monitoring flow sheet for Lunesta lacked targeted behaviors and was not put into effect until 11/28/14, 8 days after the medication was ordered for the resident.

The December behavior monitoring flowsheet for Lunesta lacked targeted behaviors.

Observation on 12/2/14 at 4:25 P.M. resident slept while in bed.

On 12/3/14 at 8:39 A.M. resident stated he/she has never slept well at night and preferred to take naps during the day.

Interview on 12/4/14 at 8:04 A.M. with direct care staff Q stated the resident voiced his/her needs appropriately, and did take naps during the day.

On 12/4/14 at 9:06 A.M. licensed nursing staff M revealed behavior monitoring sheets were put into effect as soon as a resident was admitted or when the medication was ordered. He/she stated all behavior monitoring flow sheets had target behaviors and if a PRN medication was given the electronic medical record (EMAR) and behavior monitoring flow sheets would reflect this.

On 12/4/14 at 11:02 A.M. administrative licensed nursing staff D revealed the nurse who admitted the resident put into effect behavior monitoring flow sheets with target behaviors listed. He/she expected the behavior monitoring flow sheet to reflect the EMAR.

On 12/4/14 at approximately 1:20 P.M. pharmacy consultant GG stated he/she expected nursing

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staff to identify target behaviors and the behavior monitoring flow sheets to reflect the EMAR. He/she stated since the residents at this facility are here such a short time pharmacy staff try to review the behavior monitoring sheets weekly.

The policy and procedure for medication use with an approval date of May 2014, provided by the facility revealed the pharmacists activities included monitoring and assessing patient response to medication therapy.

The pharmacy consultant failed to notify the facility for this resident who recieved psychotropic medication that lacked targeted behaviors.

- The electronic medical record revealed resident # 67 was admitted on 11/26/14.

The care plan updated on 12/2/14 revealed the resident experienced anxiety and staff monitored for this behavior.

Review of the electronic medication record revealed the resident had an order for Xanax (a medication used for anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) 0.25 milligrams (mg) by mouth (PO) as needed (PRN) for anxiety three times a day with an order date of 11/26/14.

Review of the behavior monitoring flow sheet for Xanax revealed the November and December flow sheets lacked targeted behaviors for Xanax.

Observation on 12/3/14 at 9:10 A.M. resident visited with tablemate's in the dining room.

Interview on 12/4/14 at 8:04 A.M. with direct care

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staff Q stated the resident voiced his/her needs appropriately, and had no behaviors.

On 12/4/14 at 9:06 A.M. licensed nursing staff M revealed behavior monitoring sheets were put into effect as soon as a resident was admitted or when the medication was ordered. He/she stated all behavior monitoring flow sheets had target behaviors.

On 12/4/14 at 11:02 A.M. administrative licensed nursing staff D revealed the nurse who admitted the resident put into effect behavior monitoring flow sheets with target behaviors listed.

On 12/4/14 at approximately 1:20 P.M. pharmacy consultant GG stated he/she expected nursing staff to identify target behaviors and the behavior monitoring flow sheets to reflect the EMAR. He/she stated since the residents at this facility are here such a short time pharmacy staff try to review the behavior monitoring sheets weekly.

The policy and procedure for medication use with an approval date of May 2014, provided by the facility revealed the pharmacists activities included monitoring and assessing patient response to medication therapy.

The pharmacy consultant failed to notify the facility for this resident who recieved psychotropic medication that lacked targeted behaviors.

- The 5 day Minimum Data Set (MDS) dated 11/28/14 revealed resident # 70 received hypnotics (a medication used for sleep) and anxiety (a medication used for anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear))

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medication.

The care plan updated on 12/2/14 revealed the resident received psychotropic medications but lacked information on specific psychotropic medications the resident received and targeted behaviors.

Review of the electronic medication record revealed the resident had an order for Ativan (an anti-anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) medication)) 1 milligram (mg) by mouth (PO) as needed (PRN) every four hours for anxiety with an order date of 11/25/14. The resident received this medication daily 11/25/14-12/2/14. An order for Ambien (a hypnotic (a psychotropic medication) given for insomnia) 5 milligram (mg) by mouth (PO) as needed (PRN) daily for sleep and had an order date of 11/25/14. The resident received this medication 11/26/14, 11/29/14, 11/30/14 and 12/1/14.

Review of the November behavior monitoring flow sheet for Ativan revealed the resident had received this medication on 11/28/14 and 11/29/14. The behavior monitoring flow sheet for Ativan lacked targeted behaviors, and was not put into effect until 11/28/14, 4 days after the resident was ordered this medication.

Review of the November behavior monitoring flow sheet for Ambien revealed the resident had received this medication on 11/29/14. The behavior monitoring flow sheet for Ambien lacked targeted behaviors, and was not put into effect until 11/28/14, 4 days after the medication was ordered for the resident.

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Review of the December behavior monitoring flow sheet for Ativan and Ambien revealed the resident received Ativan and Ambien on 12/1/14, both medications lacked documentation for targeted behaviors.

Observation on 12/1/14 at 11:33 A.M. resident voiced complaints of pain and he/she stated nursing staff gave him/her pain medications when he/she asked.

Interview on 12/4/14 at 8:04 A.M. with direct care staff Q stated the resident voiced his/her needs appropriately, and displayed agitation and was verbally abusive at times.

On 12/4/14 at 9:06 A.M. licensed nursing staff M revealed behavior monitoring sheets were put into effect as soon as a resident was admitted or when the medication was ordered. He/she stated all behavior monitoring flow sheets had target behaviors and if a PRN medication was given the electronic medical record (EMAR) and behavior monitoring flow sheets would reflect this.

On 12/4/14 at 11:02 A.M. administrative licensed nursing staff D revealed the nurse who admitted the resident put into effect behavior monitoring flow sheets with target behaviors listed. He/she expected the behavior monitoring flow sheet to reflect the EMAR.

On 12/4/14 at approximately 1:20 P.M. pharmacy consultant GG stated he/she expected nursing staff to identify target behaviors and the behavior monitoring flow sheets to reflect the EMAR. He/she stated since the residents at this facility are here such a short time pharmacy staff try to review the behavior monitoring sheets weekly.

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F 428	Continued From page 40 The pharmacy consultant failed to notify the facility for this resident who recieved psychotropic medication that lacked targeted behaviors. The facility failed to identify specific behaviors that needed monitoring for this resident who received a psychotropic medication.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		

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hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 8 residents. Based upon observation and interviews the facility failed to ensure linens were hygienically cleaned.

Findings included:

- On 12/4/14 housekeeping staff X stated the facility only laundered privacy curtains after residents with a diagnosis of Clostridium Difficile (contagious bacteria characterized by foul smelling frequent bowel movements) isolation was discontinued. Housekeeping staff X stated all other laundry was processed off site.

On 12/4/14 at 9:05 A.M. the water temperature of the facility's washer measured 123.4 degrees.

On 12/4/14 at 9:15 A.M. maintenance staff Z stated the facility did not send out water greater than 120 degrees. Housekeeping staff Y present at that time stated the facility used bleach when washing the curtains to ensure the curtains were hygienically cleaned.

On 12/4/14 at 9:20 A.M. housekeeping Y stated the facility placed bleach in the dispensing unit of the washer when washing the curtains but he/she

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F 441	Continued From page 42 did not know the amount of bleach staff placed. Housekeeping staff Y stated the facility did not have a policy regarding processing of on-site laundry nor did the facility have anything from the manufacturer of the washer regarding appropriate methods to use to produce hygienically clean products. The facility failed to ensure the privacy curtains were hygienically cleaned.	F 441		